

**FIRST STEPS FINANCIAL INFORMATION FORM**Check one: ☐ Initial ☐ Update

Child's Name: \_\_\_\_\_

CBIS No. \_\_\_\_\_ SSN: \_\_\_\_\_

**INCOME INFORMATION:**

Most recent gross family income: \_\_\_\_\_

Number in Household: \_\_\_\_\_ Family Share Category: \_\_\_\_\_

Family applied for exemption from Family Share: ☐ Yes ☐ NoIf yes, check reason: ☐ Temporary Suspension/Waiver ☐ Inability to PayFamily was approved for exemption: ☐ Yes ☐ No ☐ Pending**KCHIP/MEDICAID INFORMATION:**Family's income is below 200% of poverty level: ☐ Yes ☐ NoChild already has a medical card: ☐ Yes ☐ No

If yes, please write 10-digit number: \_\_\_\_\_

Family needs to be contacted about completing KCHIP/Medicaid application.

☐ Yes ☐ No

Family went to their local Department for Community Based Services (DCBS) office (or sent representative) and completed KCHIP/Medicaid application.

☐ Yes ☐ No

Application Submission Date: \_\_\_\_\_

Application was approved for ☐ KCHIP ☐ Medicaid (includes HCBS waiver).Application was denied for ☐ KCHIP ☐ Medicaid (includes HCBS waiver).

Reason(s) given for denial: \_\_\_\_\_

☐ Application is still pending.☐ Family refused to apply. Reason: \_\_\_\_\_

*(Note: Families with incomes in category one must apply for KCHIP/Medicaid. Families refusing to apply (except for religious reasons) will be assessed \$100/month Family Share. Check category 7 on the appropriate summary sheet (either Demographic Changes/POE Home Visit Form or IFSP Meeting Form).*

Child's Name: \_\_\_\_\_

CBIS No. \_\_\_\_\_ SSN: \_\_\_\_\_

**INSURANCE COVERAGE:**

*(Note: Families who are covered by private insurance and Medicaid need to be reminded that they signed a "Third Party Liability Health Insurance" form during the Medicaid application process, agreeing to have their insurance billed first for all services that may be covered by Medicaid. This was a condition of accepting the medical card. (State regulation references: 907 KAR 1:001 & 1:005. State statute references: KRS 205.520 & 520.624).*

Child is currently covered by insurance. ☐ Yes ☐ No

For children with insurance coverage only: Parents want to use their insurance.

☐ Yes ☐ No

Insurance Company's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone No. (\_\_\_\_\_) \_\_\_\_\_ Policy No. \_\_\_\_\_

Insurance Effective Date: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_

Patient ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Policyholder's Relationship to Insured: \_\_\_\_\_

Policyholder's SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policyholder's Employer: \_\_\_\_\_

Minimum annual dollar amount that the insurance company will have to pay in this calendar year in order for Family Share fee to be refunded: \_\_\_\_\_

Family has chosen provider(s) who can receive payment from insurance.

☐ Yes ☐ No ☐ Some providers can; others cannot. ☐ Unknown

Comments: \_\_\_\_\_

Completed by: \_\_\_\_\_

Name printed. Please denote ISC or PSC.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date

SC's Phone Number: (\_\_\_\_\_) \_\_\_\_\_

*Keep this form in child's file. Do not send to CSHCN (unless requested) or CBIS.*